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INSIDE

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Corporate compliance: It's not for Medicare only

Reporting system may avert legal, regulatory problems

Fraud and abuse. Office of Inspector General (OIG). Operation Restore Trust. Stark II. Wedge audits. Private duty providers that are not Medicare-certified may take comfort in not being intimately familiar with these terms. However, that collective sigh of relief may be premature. The long arm of both federal and state governmental oversight may touch your operations in ways you've never thought about.

Private duty providers face a plethora of potential legal and regulatory issues. Depending on the state you operate in, you may be subject to all-payer fraud and anti-kickback laws, common law contract abuse precedents, and statutory consumer protection laws, to name a few.

Being on the wrong side of any one of these areas of exposure could cost your company its license to operate, individual employees their professional license, bring criminal convictions, fines, and malpractice litigation.

"About the only thing that can't happen is disenrollment from Medicare and Medicaid programs," says **Deborah Randall**, partner in the health law practice of Arent, Fox, Kintner, Plotkin & Kahn. Randall practices out of the firm's Washington, DC, office.

Still, with so much scrutiny on Medicare, private duty providers may feel relatively insulated. Randall cautions against such thinking. "With concern for vulnerable populations, health care [generally] is actively reviewed by both federal and state agencies. That includes tangential relationships," she explains.

Compliance plans set expectations

Corporate compliance plans are one means of managing your company's exposure to regulatory, legal, and even ethical violations. They "establish owners' expectations about standards of conduct throughout the organization that include appropriate behaviors, documentation, interactions with contractors, suppliers, and referral sources; everything that has a bearing on the reflection of the company," according to

Randy Boston, RN, MA, president and chief executive officer of Healthcare Executive Resources, an Austin, TX-based consulting firm.

A corporate compliance program won't guarantee your organization will never have a violation, but by focusing and streamlining your oversight, it may make the task of compliance easier. It may also increase staff awareness of issues, create a mechanism for reporting concerns and set an ethical tone that will ultimately help you identify potential problems before others do.

Corporate compliance may also give you a competitive edge, Boston says. "In managed care contracts and bidding, one of the things people look for is honesty and integrity. And this is one expression of that," he advises.

Still, some providers may hesitate to develop a formal corporate compliance program because they believe it's expensive and onerous. But that's not necessarily so. You can develop a comprehensive and easy-to-administer corporate compliance plan by taking the following actions:

• **Make a commitment.**

Developing a corporate compliance program requires a commitment of organizational resources, from expense to time spent re-evaluating policies and procedures. "The company owner has to sit and take a hard look at stuff. Making a decision to [develop a program] is a commitment. It's more than writing it down; it's living the life. You can't just say, 'I have integrity.' The document can't sit on a shelf. It must be active," Boston advises.

• **Identify exposure areas.**

Identify exposure areas by reviewing all contracts and relationships. Keep in mind that your contracting partner's status with governmental programs may draw you into the requirements of those programs.

For example, if you provide supplemental staffing under contract to a hospital, that agreement makes your company part of that organization and subject to the Medicare and Medicaid regulations under which it operates, Randall says.

Review your existing policies and procedures that involve documentation standards, billing procedures, ethical conduct, other internal control measures, and external relationships, Boston recommends. Include such things as management contracts, acquisition agreements, vendor and supplier relationships, inventory control mechanisms, and relationships with physicians and other referral sources.

Finding potential problems may require some detective work. A common problem is that "people do deals the chief executive officer (CEO) doesn't know about that have legal or regulatory violations or implicate the company. It happens a lot," says Randall.

Employees may also violate laws or commit ethical breaches without knowing it, and their actions may not surface until you actually implement the plan. **(See related article on OIG guidelines, p. 40.)**

• **Write the plan.**

A corporate compliance plan usually includes:

— a proclamation of ethical behavior and standards of conduct;

— written policies and procedures that address exposure areas through accountabilities and control measures;

— identification of a corporate compliance officer and a compliance committee;

— a provision to educate staff;

— a mechanism for staff to report problems and concerns;

— disciplinary actions that result from wrongdoing.

The compliance plan policies and procedures usually already exist in various other policies. "They're technically in agency policies, but this just puts them in one place," says **Bonnie Whorton**, MS, executive director of Home Care of Mid-Missouri in Moberly.

• **Integrate corporate compliance and performance improvement.**

Combining corporate compliance and performance improvement activities will make corporate compliance part of your ongoing review

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procedures and subject it to the critical thinking used in performance improvement, according to Boston. "It establishes a process to monitor things every day and if you find a mistake, to deal with it," he says.

For example, routinely checking that physician orders are signed before you bill should flag exceptions. This should not only prevent you from submitting incomplete claims, but also help identify process glitches, facilitating correction of both individual and systematic errors.

• **Identify a corporate compliance officer.**

Designate a senior-level person to address corporate compliance issues, oversee program implementation, and report on its activities to a compliance committee. Some larger, Medicare-certified agencies create a corporate compliance position. If your organization is not substantial or complicated enough for such an expense, add corporate compliance to the responsibilities of a top manager with direct access to the CEO.

"A lot of people use the human resources person, but others choose the [CEO] or quality assurance person. It should not be the CEO, because they're already at the top of the heap, and the aura of the CEO may decrease the willingness of people to call in," Boston says.

At Home Care of Mid-Missouri, the assistant director serves as the compliance officer. She reports to Whorton.

• **Designate a compliance committee.**

The corporate compliance committee provides a forum to monitor overall compliance, advise the compliance officer, and develop strategies to improve compliance activities. Usually the CEO and governing body are the members. In organizations without a board of directors, it should include the CEO and senior managers.

The Home Care of Mid-Missouri compliance committee has six members. Four represent the board and senior management. Two represent employee groups; one is a field nurse, and one is an office staff worker, according to Whorton.

• **Educate employees.**

One of the main purposes of a corporate compliance plan is to raise awareness of potential problems throughout the organization. The effect of someone unintentionally violating a law or creating a conflict can be the same as a willful offense, so it is important that employees understand the breadth of compliance issues. Educate them about the purpose of corporate compliance, the types of potential problems, the monitoring that will occur, and the penalties that may result from violations.

"It's good doing the training, especially with paraprofessionals so that they know, yes, there's a mechanism to report problems and there's a penalty for wrongdoing," says Whorton. "This is common sense stuff. Everyone's doing it, but now they've signed [off on] it."

• **Develop a reporting mechanism.**

Employees should know what to do and whom to go to when they see a problem or have a concern that impacts on corporate compliance. Not establishing a reporting mechanism and not making clear that employees will not suffer recrimination for bringing issues forward can create a whole set of operating problems.

"If you have [a compliance] statement without an avenue, you will shortly end up with a contorted situation where the employee thinks, 'They didn't mean what they said,' or feels no one listened. They may go outside to Medicare, Medicaid, or the state, or even talk to clients. You will then lose business in a different way. As a client, I may hear an employee grumbling and then you'll never know I didn't call. It's a silent loss," Randall explains.

Home Care of Mid-Missouri uses a compliance hot line, according to Whorton. Since implementing its program about a year ago, the agency has not received any complaints, but it is "important to encourage people to report things and know there'll be no recrimination," she says.

The company's compliance policy includes the following statement: "It is the duty of each employee to report any suspected violation to the compliance officer. If you are not comfortable approaching the compliance officer, you should contact a compliance committee member or the agency administrator. If any of us fail to take seriously the importance of this compliance program, the adverse consequence in terms of our business and company image can be extremely serious. Be assured that the company stands ready to assist you in any way, as each of you are the key to making the compliance program a success."

Corporate compliance requires resources at a time when many providers are struggling. It is also "not some magical mystical thing that will protect you," Boston notes. However, "it's not that hard and it will make the agency stronger," Whorton adds.

Without a spurt in reported violations, life after compliance plan development may seem anticlimactic. However, don't let inactivity lull you into a false sense of security.

"Don't get complacent! Just because no one calls

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up the hotline, it doesn't mean everything's OK. You never know when someone is going to come in. Don't let the government be the first person to tell you have a problem," Boston advises. ■

OIG guidelines useful for private duty

The Department of Health and Human Service's Office of Inspector General (OIG) issued compliance guidelines for federal laws in August 1998. The guidelines apply specifically to providers operating under the Medicare program, but may serve as a useful template for private duty providers developing a corporate compliance program. Intended only as a reference, and not an antidote to prosecution, the guidelines cover the following areas:

- fictitious care plans, certifications and beneficiary signatures;
- billing for services that are either substandard or not performed;
- billing for services that are medically unnecessary based on a patient's documented medical condition;
- duplicate billing and failure to refund credit balances or overpayments promptly;
- providing incentives to potential referral sources that may violate anti-kickback laws;
- billing for services provided to patients who are not homebound;
- over- and underutilization of services, including financial incentives based on the number of visits and/or revenue generated;
- billing for non-reimbursable services such as coordination of care;
- arrangements with physicians who violate the Stark anti-referral law;
- financial incentives that reward practitioners for referrals to the home health agency or otherwise violate the anti-kickback statute;
- patient abandonment or termination of services.[1]

Don't forget proscriptions of activities that involve conflict of interest, antitrust and political activism, says **Randy Boston**, RN, MA, president and chief executive officer of Austin, TX-based Healthcare Executive Resources, a health care consulting firm.

Keep in mind that "it's not just what's happening in your agency, it's what people think is going on that is important," he says. For example, if you invite your top referral sources to a company Christmas party, your only intention may be acknowledging those with whom you have a good relationship and who value your services. Others may interpret the action as an inducement for more business.

Copies of the OIG guidelines are available on the Department of Health and Human Services. Web site: www.dhhs.gov/progorg/oig.

Reference

1. Adapted from presentation given by Arent, Fox, Kintner, Plotkin & Kahn, Washington, DC. ■

Beyond cost-plus pricing

Market, customer demands can determine charges

You've decided what new private duty service you'd like to offer. **(See December 1998 *Private Duty Homecare*, p. 163.)** Now, what do you charge for it? Some providers add administrative and overhead factors to their direct cost of care to arrive at a price. To determine personal care service rates, for instance, they would start with the $7.50 per hour in salary and benefits paid to caregivers. To that, they would add a $1.50 per hour overhead factor to cover scheduling, supervision, and billing costs. Finally, they would include a $1.35 per hour markup to meet their 15% net income goal, arriving at a $10.35 per hour charge.

Such a methodology may be appropriate in some instances, but in others it may cause you to either price your service out of the market or undercharge, according to **John Richter**, CPA,

Pricing Decision Questions

- Do you have clearly defined marketing strategies?
- Do you know your service's position in the market?
- Do you know your target audience?
- Is your market changing?
- What does the market want or need from your service?
- Is the service price sensitive?
- Is the visibility of the service high or low?
- Do you know the unit costs of providing the service at the desired level of quality?
- Will a change in price increase volume?
- Do you know the variable cost of the service?
- How will volume affect the cost per unit?
- What is the competition doing and thinking?

Source: Larson, Allen, Weishair & Co., Charlotte, NC.

principal with Larson, Allen, Weishair & Co., a health care consulting firm in Charlotte, NC. He recommends using three variables to determine pricing:

- market demand;
- customer needs;
- third-party contracting parameters.

"Knowledge of your costs is essential, but you have to understand what's in your market. Some services may have a 5% markup, while others, where you're offering something dramatic and unique, may have one that's 50%. It really gets down to a philosophy of thinking in terms of the market place instead of cost plus," Richter says.

That marketplace mindset translates into new terminologies and new methods of operating. "My most successful private duty clients operate like retail stores. They don't do financials on a monthly basis, but instead set weekly growth measures and targets," Richter says.

They also think in terms of revenue and sales instead of reimbursement, and customers instead of clients and patients, he adds.

Many providers emphasize the quality of their services, and use that as a justification for their pricing structure. However, "Quality in health care is very difficult for consumers to distinguish unless there's a negative reflection in the media or community of the provider. Absent that, quality is perceived to be the same," explains Richter. It is an especially hard sell for highly competitive services.

Determining the right price for your service requires "a constant awareness of what's happening in the marketplace. Use information that customers switching companies tell you, telephone inquiries, and published rate sheets of competitors," Richter advises.

Also, look at other measures such as operating efficiency and customer satisfaction. Know how well your service stacks against the competition. "A good operator knows what they're particularly good at through their assessment process of quality, operating efficiency, and customer service," he adds.

Other factors that affect pricing include the uniqueness of a service, its relative newness in the market, the number of competitors, and the visibility of the service. **(See Pricing Decision Questions, at left.)**

Unique services usually demand higher prices. "If the competition is not providing it, or if it's in a way that's so exceptional that clients are referring to you, you can increase the price," he says. "Your most recent performance will tell you. If you're fast growing and few are providing it [in the same way], then [you can charge more]."

New services or those opening in new territories may have the most competitive prices. Sometimes providers competitively price certain services in the hopes that when a customer has other needs, he will consider using services that are more profitable, Richter notes.

No service should be unprofitable in the long run. There should be no loss leaders, Richter advises. If your service is priced competitively and is unprofitable, closely scrutinize the operations.

"You need detailed cost management reports to assess the organization and either increase productivity or decrease administrative expenses," he says.

Don't scrimp on labor costs. "If you pay lower rates and no benefits, you will have a higher profit margin in the short run. But in the long run, you may not be able to provide the service. As soon as profitability becomes an issue, and you've done everything you can to be profitable, then you need to make a serious decision about whether you can reasonably continue to offer the service." ■

SOURCE

- **John Richter**, CPA, Principal, Larson, Allen, Weishair & Co., 128 N. Tryon, Suite 1310, Charlotte, NC 28202. Telephone: (704) 377-6532.

Alzheimer's respite program is good for the community

Speedy response, backup support required

With grant funding from a community foundation, an Alzheimer's Association chapter and private duty provider joined forces to develop an emergency respite program for Alzheimer's patients and their caregivers.

The Alzheimer's Association of Northeastern Wisconsin and Extended Family Inc. in Neenah and Appleton, respectively, recognized the difficulties families of Alzheimer's patients face when the patient's primary caregiver can no longer care for their loved one. Other family members may be willing to take over but can only do so after making arrangements to be absent from their own families, workplace, and other obligations, all of which can take time. Meanwhile, the family needs someone to step in and find care for the Alzheimer's patient, explains **Kim Marheine**, MSE, RMT, program specialist for the Alzheimer's Association.

Enter the Emergency Dementia Service (EDS). Modeled after a similar program in the Milwaukee area, it makes emergency placements for Alzheimer's patients whose primary caregivers suddenly become unable to care for them. The program received initial funding in 1997 that has been renewed through November 1999.

The EDS began by blanketing the community with flyers announcing the program. The flyers were distributed to all nursing homes, group homes, emergency rooms, assisted living facilities, physicians with large geriatric practices, home care agencies, police and fire departments, and special care units in the program's three-county (Outagamie, Calumet, and Northern Winnebago) service area.

They outlined the criteria for the program, the services offered, and gave instructions about accessing it. The flyer also emphasized that grant funding was available to pay for services provided under the program.

At the same time, the Alzheimer's Association began an education campaign among providers and Alzheimer's families. "We provide technical assistance to facilities. Some don't understand that they have Alzheimer's patients, and they require a unique environment, staffing, and supervision," Marheine explains.

Criteria for the program include:

- Patient is over 60 years old with a diagnosis of Alzheimer's disease or related dementia.
- Family resides in Outagamie, Calumet, or Northern Winnebago counties.
- The patient has a primary caregiver, but suddenly experiences a temporary or permanent loss of caregiver support due to illness, hospitalization, death, or out-of town travel.
- Patient has a primary physician.
- The caregiver or other responsible party is available to give informed consent to participate in the program.

Making life easier

EDS emphasizes a sudden loss of caregiver support and an immediate need to place the Alzheimer's patient. For example, a caregiver who found out on Monday that he would require surgery on Friday would not qualify for the program because of the several days it takes to make arrangements for his loved one, Marheine explains. The association has two other grant projects to deal with planned absences and purchasing items that make life easier for Alzheimer's families.

Families may directly access the service, or health care facilities may do so on their behalf. Calls go to Extended Family as the project case management service. So far, Larson has personally handled each case.

After receiving the referral call, Larson makes an on-site assessment of the situation. She determines the best type of placement given the patient's status, the nature of the caregiver's problem, and available family support. For example, if a patient had more acting out behaviors, such as yelling or pacing, she would likely arrange for home care rather than adult home placement.

The pre-implementation provider education paved the way for smooth and speedy placements despite sometimes-missing information such as a complete medical history and full dementia assessment, Larson says.

Most of the calls occur early in the morning, and take from one to four hours of Larson's time. "You need someone who can respond at the drop of the hat, and you have to have backup," she says.

Prompt response is critical. In one situation, a husband-caregiver broke his leg and was transported to the hospital along with his wife. Although Larson went to the emergency room as soon as she received the referral call, they already had problems with the discharge planner trying to get them home, she says. Larson placed the wife in

SOURCES

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- **Kim Marheine**, MSE, RMT, Program Specialist, Alzheimer's Association of Northeast Wisconsin, 201 E. Bell St., Neenah, WI 54956. Telephone: (920) 727-5555.

a local group home until the husband recuperated enough to resume caregiving.

Larson charges a discount off her normal $60 case management fee for program participants. Although grant money is available to offset both the case management and placement charges, most families either have insurance coverage or pay out-of-pocket for the services, according to Larson. "We expected high costs and that it would require a longer placement time," she says.

Families who access the EDS program are "incredibly appreciative for someone who is there and can help put the pieces together," Larson says. However, not that many have taken advantage of it. A concerted education campaign by the Alzheimer's Association to increase families' awareness of the importance of advance planning and developing backup resources has paid off, according to Marheine. EDS program education may also have increased community providers' willingness to offer more affordable short-term service packages.

Editor's note: We welcome readers' new program and service ideas. If you would like to share your experiences for future business development articles, please contact us at (301) 589-1974. ■

Forging better ties with physicians

Education, clear communication are the cure

Wary of violating Medicare regulations and unaware of the role of private duty services, physicians may not use home care as effectively as possible for the benefit of their patients. Private duty providers can educate and forge better relationships with physicians that will ultimately benefit patients by taking a few simple measures.

Education is the first step. "Doctors have very little awareness of home care beyond catastrophic needs. There are huge areas where primary care practitioners are missing the boat," says **Lawrence Bernstein**, MD, chief medical officer of Longmeadow, MA-based Jewish Geriatric Services.

Physicians often overlook early warning signs of problems and don't make a connection with how home care can help improve the situation, according to Bernstein.

"Most primary care physicians recognize only 25% to 40% of modest disfunctionalities such as gait dysfunctions, urinary incontinence and sensory deficits. For example, they may not recognize that an otherwise relatively independent patient who needs to be hoisted on to the exam table is at risk for falling in the shower and needs PT and OT," he explains.

"Or, even if she does associate a patient's yellow undergarments with urinary incontinence, the physician may not see either the patient's perception of the problem or the role for home care. The patient may be fearful that her family will place her in a nursing home, or she may be leery of going out for fear of urinating in public. A thorough home assessment may indicate the person needs a bedside commode or rearrangement of furniture to make it to the bathroom quicker," Bernstein adds.

After the fall

Falls are another condition that physicians fail to associate with home care, according to Bernstein. After determining the patient didn't break any bones or suffer any disorientation, they often view a fall as just something that happened and may send the patient home with no further follow-up. Yet, "those over sixty five who experience one fall are at great risk for subsequent morbidity," Bernstein explains. And what appears as a minor fall to the physician, "may be devastating to the patient. They stay home and are less confident," he notes.

Other physicians may have Medicare homebound status and skilled need requirements so deeply ingrained in their vision of home care that they either don't realize when a patient can benefit from private duty or they don't offer it. However, "if patients don't qualify for Medicare, the family will usually pay for it if they understand the need," Bernstein asserts.

Physicians may also be unaware of community resources available for patients without resources.

For example, local councils on aging provide shopping and food bank services for the elderly.

Home care providers readily see how their services benefit patients. Conveying that benefit to busy physicians who may not even recognize the underlying problem, much less the home care link, is a challenge that can be overcome, according to Bernstein. Here are some suggestions:

• **Use case studies.**

Use case studies to present problems from a patient's perspective and show how home care helped the situation, he suggests. For example, rather than a didactic discussion on falls, detail a real-life patient fall experience. Explain the patient's status and feelings both before and after the fall. Describe the interventions used to make the patient more secure and less prone to future incidents.

• **Be brief.**

Already inundated with paperwork, physicians won't read voluminous and highly detailed communiqués. Keep written information brief. "It doesn't take a lot of time. You can do it in a few minutes," Bernstein says.

• **Be clear.**

Written communiqués should also be succinct and to the point. "Most communication [from home care providers] is useless. It's not in a form that's useful; it's full of home care jargon and abbreviations and it's far, far, far too detailed. You should state what the patient has, what you intend to do and how long it will take you. For example, 'The patient has had a stroke on the left side and is receiving rehab. Our goal is to have her bathe and dress independently and it's going to take us two months to get there,' not 'She's 13% stronger on the left side and 10% weaker on the left,'" Bernstein explains.

• **Consider using new forms.**

Even for private pay patients, home care providers tend to use a Medicare Certificate of Medical Necessity (485) type format for clinical updates, according to Bernstein. But "they're designed for Medicare, not for me," he says. Consider a different clinical update form, he suggests. "It can be 30 words or less. Just say, 'The patient's had a CVA of the left hemisphere and she now dresses and bathes independently. Our concerns are that she frequently urinates and is dizzy when she stands up. I've asked her to follow up with you on these issues.'"

Spectrum Home Health Care, also located in Longmeadow, uses a one-page clinical update form for certain patients, according to **Linda Donoghue**, RN, MPA, CNA, CHCE, executive director. It participates in a congestive heart failure (CHF) disease management program, and sends weekly updates to physicians. The document is titled "CHF Protocol Update," and in bullet points provides the patient's vital signs, weight, and any exacerbations of his or her disease.

• **Provide resource information.**

Spectrum Home Health Care not only sends all first time-referring physicians information about its services, but also those of its affiliated system, including adult day care and case management. Spectrum also sends a copy of the American Medical Association brochure "Medical Management of the Home Care Patient: Guidelines for Physicians."

Community resource information is also helpful, according to Bernstein. "It's a teaching thing so that the physician gets a sense of what's going on."

• **Create a profile for each medical practice.**

When establishing a relationship with a physician or a group practice, ask the office how, when, and what you should communicate. Every practice has a protocol about when faxes are appropriate over phone calls, for example, or when each physician is available for phone consultation, Bernstein explains.

• **Establish internal communication protocols.**

"One of the things that drives me crazy is when a doctor calls in and no one knows who asked to speak to him," Donoghue says.

To avoid frustrating the physician and creating a negative impression of your company, develop a protocol to respond to physician calls. Require field staff to notify their clinical managers when they've left a message for a return phone call, in the event that the physician calls the office rather than the staff member's beeper or message number. Ask anyone who is expecting a return phone call from a doctor to notify the receptionist so that she can help locate the person when the call comes in, Donoghue suggests.

• **Find the "it" person.**

"Make sure you know who in the doctor's office directs him and have good communications with them. Every doctor has one of those persons and when you find them, 99% of your problems are gone," advises **Bonnie Whorton**, MS, executive director of Home Care of Mid-Missouri in Moberly.

• **Send introductions and thank-yous.**

Spectrum Home Health Care sends letters of introduction to first-time referring physicians. "Thank you for the privilege of caring for [patient's

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name]," it begins. The letter then identifies the primary nurse, therapist, and / or paraprofessional involved with the case. It also invites physicians to review Spectrum's policies and procedures.

Facts about your service are helpful, but don't overdo marketing pieces, Bernstein recommends. "Don't provide a lot of flowery information. Just state it as succinctly as possible."

Good communication, especially when developing a new relationship, is critical. "For the first one or two patients, communicate like crazy. But don't call the doctor just to say the patient's OK. Provide meaningful information," Bernstein advises.

• **Consider yourself a consultant.**

"Think of yourself as a consultant who is teaching me about my patient," Bernstein suggests.

Editor's note: Copies of the American Medical Association (AMA) booklet "Medical Management of the Home Care Patient: Guidelines for Physicians" are $4 each; $75 for 25. They are available from the AMA at (312) 464-5000. ■

Self-directed work groups eliminate turnover

Paraprofessionals give managers more control

Self-directed work teams may dramatically lower paraprofessional turnover in your organization. Consider the case of Boise, ID-based St. Alphonsus Home Health. Since implementing a self-directed work team system among home health aides (HHA) about five years ago, the agency reduced turnover to virtually zero.

"People only leave when they move out of the area or graduate from nursing school," says **Alice Ennis**, MSN, RN, C, clinical manager.

Such dramatic results are no fluke, according to Ennis. They are not only possible, but even probable for other providers who make a commitment similar to the one St. Alphonsus made when initiating the system, she says.

With a team-oriented managerial philosophy supporting them, the self-directed HHA work group initially underwent an extensive training program and developed a profile of an ideal HHA. Today, they schedule themselves and participate in monthly educational and problem-solving meetings and now-infrequent HHA candidate interviews.

Take control

The idea for the new approach came from Ennis' attendance at a nursing conference that emphasized the importance nurses place on having control over their work life, combined with some research she'd seen about nursing homes lowering turnover by encouraging certified nursing assistants to participate in the organizations.

"It just seemed like a natural thing to do. We tried to develop a climate where people are responsible for their own destiny. We like people to develop as much as possible," she says.

St. Alphonsus' self-directed work group (SDWG) process began with management and licensed staff education. "This has to be consistent with managerial values and climate, and the licensed staff have to understand and embrace it," Ennis explains.

Next came setting the organizational culture with a new mission statement: "We strive to create together a work environment that is affirming of individuals' worth and self-esteem and that reflects trust and mutual respect."

The entire organization had a hand in developing it. "It applies across the board. It's part of our everyday life, not just the home health aide's," Ennis says.

From there, an extensive HHA education program began. It covered interviewing skills, group dynamics, assertiveness, communication, delegation style, and problem solving, and totaled about 10 hours for each HHA. At the end of the training, the HHAs developed an ideal HHA profile to use in hiring new employees.

Profile components include:

• maintaining personal and professional boundaries between oneself and your client;

• being non-judgmental and non-threatening

SOURCE

- **Alice Ennis**, MSN, RN, C, Clinical Manager, St. Alphonsus Home Health, 427 N. Curtis, Boise, ID 83706. Telephone: (208) 367-7302.

with patients and co-workers;
- having good interpersonal skills;
- understanding and supporting patient independence.

The profile served dual purposes. It not only outlined expectations for job candidates, but also established standards for existing employees. "It gave peer pressure. If this is what I want you to look like, this is what I'm going to do," Ennis explains. St. Alphonsus added the profile to its other employment standards, which include:
- background checks;
- completion of application;
- previous HHA work experience;
- reference checks.

Find the right person

Existing HHAs evaluate applicants against the profile through a series of prepared questions asked in group interviews. Ennis advises applicants beforehand that they will meet with herself and up to five other HHA-employees. The questions are designed to determine the applicant's problem-solving approach and run the gamut of patient care situations.

For example, one asks what the applicant would do if she entered the home of a client who was crying and saying she'd just had an out-of-body experience. "We're looking for someone who takes a minute and thinks about how to respond to a bizarre situation," Ennis explains.

On the other hand, when asked what she would do if she found a patient unresponsive, "We want someone who would jump in. We want someone who know the difference [between the two situations]."

Although Ennis makes the final hiring decision and job offer, she relies on the recommendation of the HHA-interviewers. They discuss their impressions of how a candidate fits into the profile immediately after each interview. "This is where we started setting the standard for new employees, [including] mutual respect and trust," she says.

Once hired, new employees again interact with existing HHAs. A lead HHA puts the orientation calendar together and arranges for the orientee to shadow as many HHAs as possible. They all give feedback about the new employee's performance and help develop a performance plan. "This gives them ownership in making sure the orientee succeeds," according to Ennis.

In addition to hiring and orientation, the self-directed work groups participate in St. Alphonsus's performance improvement committees and handle patient scheduling themselves. The agency has a scheduler who makes the initial case assignment based on geographic zones. However, if a HHA can't work the patient's desired visit times into her schedule, or feels she needs a break from a particularly trying case, she may negotiate and trade assignments with another HHA. In such circumstances, the HHA usually turns to her peer in the adjacent territory. The system works very well, according to Ennis.

"I can't say there's never been problems, but it usually happens when someone interferes with them," she says.

The HHAs also switch territories every quarter. "It makes the job more interesting for the HHAs, it cuts down on burnout, and it [keeps] patients [from being] too dependent on one HHA," Ennis explains.

The self-directed work groups meet formally every month for continuing education and to discuss any problems or concerns. They also participate in weekly team conferences, and through daily trips to the agency offices, have an ongoing opportunity to interact and address any issues.

Although the self-directed work groups have been very successful over time, they initially caused much upheaval. "The first six months we had a huge turnover. The existing people left. They didn't want to go through it, and they didn't trust the people they were hiring. But you have to trust that people want to do their best," she says.

Those who stuck it out reaped both professional and personal benefits. Ennis recounts the "very powerful effect" on the group of seeing how an assertiveness workshop influenced a team member who had previously been the least assertive among them. "I'm very gratified to see that they've grown as individuals as well as directing their work," says Ennis.

In addition to the time and resource commitment, the work groups require a significant, but ultimately rewarding change in management philosophy.

"It takes a definite mindset change. It's hard to

let go. It's hard to let them decide what they're going to do. [Managers think] you're supposed to control. But I feel I now have more control over their everyday work habits," she says. ■

Clarification

The March *Private Duty Homecare* did not identify the Nutrition Screening Initiative co-sponsors, which include the American Academy of Family Physicians, the American Dietetic Association, and the National Council on the Aging. The Initiative also receives grant funding from the Ross Products Division of Abbott Laboratories Inc. ■

Associations offer new business development conference

The National Association for Home Care (NAHC), the Proprietary Home Care Association of America, the Pediatric Homecare, and Hospice Association of America and the Home Care Aide Association of America are sponsoring the New Home Care Business Development Conference, "Expanding Services Beyond Medicare in a Cost-Conscious Environment." The conference, combining the National Private Pay Home and Community Services Conference, the National Home Care Aide Services Conference and the National Adult Day Care Symposium, will be held April 17-21 at the Hyatt Regency Crystal City Hotel in Arlington, VA.

Established in response to home care providers' need for in-depth information on expanding beyond Medicare, the conference addresses such topics as "From Ugly Stepchild to Cinderella: Strategies to Transform your Private Pay Home Care Program," and "Home Care Aides Specializing in Palliative Care." For more information or to register, contact the NAHC meetings department at (202) 547-5050. ▼

New hospice award announced

The American Hospital Association (AHA) recently announced a new award that, starting in 2000, will be given each year to up to three exemplary hospice programs. The *Circle of Life Award: Celebrating Innovation in End-Of-Life Care*, will honor innovative hospital, hospice, nursing home, and home care programs aimed at improving the care for those in the last days of their lives. The $25,000 award will be funded by the Robert Wood Johnson Foundation (RWJF), and is co-sponsored by the American Medical Association, the National Hospice Organization and the American

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Association of Homes and Services for the Aging.

"This award program will, we hope, serve as a beacon of inspiration for health care institutions nationwide. By telling the stories of good dying and letting other institutions know how this was achieved, we hope to help change professional and societal attitudes that often equate death with a failure of science," says **Victoria Weisfeld**, RWJF project officer for the award.

The award will be given to patient care programs that respect patient goals and preferences, provide comprehensive care, acknowledge and address family or caregivers' concerns and needs, offer a communitywide approach to care and build support systems to maintain the program.

More information on the award is available on the AHA Web site: www.aha.org. ▼

Survey shows first signs of impending nurse shortage

A recently conducted survey of 388 hospital nursing executives and recruiters indicates another nursing shortage is looming on the horizon. Unlike past shortages that generally involved too few nurses, this impending one is apparently caused by increased demand for experienced RNs in specialized areas, such as neonatal, operating room, and intensive care services.

Other factors include increased competition from other health care providers for RN labor, declining enrollment in four-year nursing programs and the increasing age of nurses. (The average age of nurses is now 44 years old, according to the U.S. Department of Health and Human Services Division of Nursing.)

One third of those surveyed last November said it took longer to recruit qualified nurses than it did six months ago. Those located in the Midwest experienced the greatest overall increase in recruitment time. Urban hospitals reported significantly more difficulty in filling vacancies, while larger and urban facilities reported an increased use of agency and contract nurses. Respondents also indicated managing flexible and temporary staffing to accommodate fluctuating patient census is a critical nurse staffing priority.

The HSM Group conducted the survey on behalf of the American Organization of Nurse Executives in cooperation with the American Nurses Association, the American Society for Healthcare Human Resources Administration, and the U.S. Department of Health and Human Services' Division of Nursing. In the future, it will be repeated and expanded to cover other practice areas, according to spokeswoman Alicia Mitchell. ■

CE objectives:

After reading this issue of *Private Duty Homecare,* CE participants will be able to:

1. Identify the purpose of a corporate compliance plan.
2. List the elements of a corporate compliance plan.
3. Name three considerations when pricing private duty services.
4. Identify ways to improve communications with physicians.
5. List activities of a self-directed paraprofessional work group. ■